

PROFILE OF ADAPTATION TO LIFE

(A) MOOD SCALE

DURING LAST WEEK, INCLUDING TODAY, HOW OFTEN HAVE YOU FELT . . .

Please mark the answer for each question that best describes how you felt this past week. Mark your answer choices, like this: X

	Answer choices				
	1 Rarely	2 Some- times	3 Often	4 Almost Always	
Vigorous?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1
Alert?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2
Full of pep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3
Happy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4
Calm and relaxed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5
Content?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6
Secure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7
Confidence in yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8
Inner calm and peace?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9

	Answer choices				
	1 Never	2 Rarely	3 Some- times	4 Often	
Discouraged?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10
Uneasy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11
Unhappy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12
On edge?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	13
Gloomy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	14
Blue?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	15
Like crying?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16
Worried?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	17
Tense?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	18
Bored?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	19
Annoyed, irritated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	20

DURING THE PAST MONTH, I'VE
(Please answer each statement below)

	Answer choices				
	1 Rarely	2 Some- times	3 Often	4 Almost Always	
Enjoyed talking with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	21
Felt trusting of people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	22
Found work useful and interesting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	23
Enjoyed people I live with	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	24
Found people accept me as I am	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	25
Been involved, interested in things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	26
Felt needed and useful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	27
Controlled my negative thinking and increased my positive thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	28
Found things I've needed coming to me by "coincidence" or "chance"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	29

	Answer choices				
	1 Never	2 Rarely	3 Some- times	4 Often	
A lack of order around me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	30
Dissatisfied with myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	31
Critical of others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	32
Annoyed, irritated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	33
An impulse to hurt someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	34
Left out of things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	35
That people treated me unfairly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	36
Bothered by sloppiness around me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	37
Disappointed in people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	38
Worried about debts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	39
Uncertain about who I really am	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	40
Unhappy about the work I do	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	41
My family finds fault with me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	42
No one seemed interested in how I really feel inside	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	43

(C) PHYSICAL HEALTH INVENTORY

Please mark one answer for each question below.
Mark your answer like this: ☒ or this ☒

	Answer choices			
	1	2	3	
DURING THE LAST MONTH, HAVE YOU . . .	Never	Some-times	Often	
Had headaches? (Past month)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	44
Felt faint?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	45
Felt hot, feverish?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	46
Had spells of dizziness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	47
Had difficulty falling asleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	48
Had chest pains?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	49
Noticed your heart beating fast?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	50
Had difficulty breathing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	51
Felt physically ill?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	52
Had back pains?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	53
Been bothered by itching?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	54
Had coughing spells?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	55
Had neck or shoulder pains?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	56
Had pains in legs or arms?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	57
Had trouble with your vision?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	58
Felt exhausted, fatigued?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	59
Waken from sleep feeling tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	60
Had a poor appetite?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	61
Been constipated (hard stools)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	62
Had an upset stomach?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	63
Had nausea (sick to stomach)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	64
Had indigestion?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	65
Had stomach pain after eating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	66
Had trouble digesting food?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	67
Had diarrhea (loose bowels)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	68

(D) PERSONAL BELIEFS

IT IS MY OPINION THAT . . . (Please answer each statement below)	Answer choices				
	1 Not Agree	2 Not Sure	3 Agree	4 Agree Strongly	
A person's soul or spirit continues after death	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	69
People will be reborn to live again on earth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	70
Mental telepathy (ESP) is a reality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	71
People have out of body experiences (astral travel)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	72
There are spiritual or non-physical forces acting in today's world	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	73
Sooner or later people will treat you as you've treated others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	74
Spiritual or psychic healing is often as effective as medical treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	75
	76	Subj #		80	
It's wrong to kill any living thing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1
Problems in life are really opportunities to learn and grow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2
People create their own reality by the kinds of thoughts they let themselves have	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3

IT IS MY OPINION THAT THE SOLUTIONS TO MAN'S PROBLEMS IN LIVING WILL BE FOUND IN . . .	Answer choices				
	1 Not Agree	2 Not Sure	3 Agree	4 Agree Strongly	
More money for scientific research	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4
More formal education for people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5
Redistributing the wealth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6
A return to organized religion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7
Social reform through better laws	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8
Daily meditation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9
Spiritual reawakening (personal enlightenment)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10
Protecting the environment, natural resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11

(E) LIFE STYLE

DURING THE PAST MONTH, HOW OFTEN HAVE YOU... (Please answer each question below)	Answer choices				
	Rarely or Never	1-2 Times /Week	3-5 Times /Week	Each Day	
Spent time with a <u>close</u> friend?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12
Shared personal problems with a friend?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	13
Washed the dishes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	14
Done household cleaning?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	15
Prepared meals?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16
Washed clothes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	17
Done physical exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	18
Taken part in active sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	19
Listened to music you enjoy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	20
Taken time to be by yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	21
Meditated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	22
Enjoyed contact with animals?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	23
Taken care of house plants?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	24
Eaten red meat (beef, pork)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	25
Eaten fish or poultry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	26
Eaten sweets (candy, cake, pie, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	27
Drunk soft drinks (Coke, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	28
Eaten <u>fresh</u> fruits (apples, oranges, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	29
Eaten natural foods (dried fruit, nuts, whole grains)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	30
Kept up with current events, (read newspaper, magazines, watch TV news)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	31
Read something about mystical, spiritual or psychic things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	32
Read something about personal psychological growth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	33

(E) LIFE STYLE (CONT'D)

DURING THE LAST MONTH, HAVE YOU . . .	Answer choices				
	1 Never	2 1-2 times per month	3 1-2 times per week	4 Almost Daily	
Gone to parties for social activities outside the home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	34
Attended meetings of civic, or other organizations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	35
Entertained friends in your home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	36
Attended a religious service?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	37
Spent time outdoors enjoying nature?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	38
Played cards or other table games?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	39
Visited with the neighbors?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	40
Done grocery shopping?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	41
Danced?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	42
Read fiction for enjoyment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	43
Participated in a study group?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	44
Taken medication for headache?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	45
Taken medication to help you sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	46
Taken medication for your stomach?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	47
Taken medication for a cold or allergy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	48
Taken tranquilizers?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	49
Taken laxatives?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	50
Used alcohol or nonprescription drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	51
Gotten high on alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	52
DURING THE LAST MONTH, HAS ALCOHOL OR DRUG USE CAUSED PROBLEMS . . .					
Between you and family members?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	53
With work (difficulty working well or going to work)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	54
With your physical health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	55
In your thinking clearly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	56

(F) ARE YOU CURRENTLY LIVING WITH A PARENT, SPOUSE, OR SOMEONE ELSE IN A CLOSE

RELATIONSHIP?

- (1) ☐ No (If you marked "No", skip to Section G below)
 (2) ☐ Yes (If you marked "Yes", answer the 8 questions below)

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DURING THE PAST MONTH, HAVE YOU AND YOUR
SIGNIFICANT OTHER (spouse, parent, etc.) . . .

	Answer choices				
	1	2	3	4	
	Rarely	Some- times	Often	Almost Always	
1. Shared personal feelings with each other?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	58
2. Been able to talk it through when angry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	59
3. Agreed about finances and budget?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	60
4. Spent enjoyable times together?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	61
5. Discussed important matters?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	62
6. Felt close to each other?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	63
7. Agreed about social activities and friends?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	64
8. Shared daily events that happened to each of you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	65

(G) ARE THERE CHILDREN WHERE YOU LIVE? (Mark one)

- (1) ☐ No (If you marked "No", skip to Section H below)
 (2) ☐ Yes (If you marked "Yes", answer the next 6 questions)

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DURING THE LAST MONTH, HAVE YOU AND THE
CHILD(REN) . . .

	Answer choices				
	1	2	3	4	
	Rarely	Some- times	Often	Almost Always	
1. Spent time talking with each other?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	67
2. Spent time doing things together?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	68
3. Openly expressed feelings to each other?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	69
4. Treated each other with respect?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	70
5. Felt close to each other?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	71
6. Done things for each other?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	72

(H) DO YOU HAVE ENOUGH MONEY TO . . .

- Pay your bills? (Mark one)
 Handle unexpected expenses? (Mark one)

	1	2	3	4	
	Rarely	Some- times	Usually	Always	
Pay your bills? (Mark one)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	73
Handle unexpected expenses? (Mark one)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	74

FROM WORKING, DID YOU EARN AN ADEQUATE AMOUNT OF MONEY LAST MONTH? (Mark one)

- (1) ☐ Earned no money from working last month
 (2) ☐ Earned enough to take care of my personal needs (spending money)
 (3) ☐ Earned enough to partially support a family
 (4) ☐ Earned enough to adequately support a family

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1. MAJOR SOURCE OF INCOME?

(Check only one answer)

- (1) ☐ Money earned from work I do now
 (2) ☐ From spouse, relative, or friend
 (3) ☐ Investments or inheritance
 (4) ☐ Welfare or public assistance
 (5) ☐ Retirement or social security
 (6) ☐ Unemployment compensation
 (7) ☐ Scholarship or student stipend
 (8) ☐ Alimony or child support
 (9) ☐ Veterans benefits

2. YOUR MARITAL STATUS (Check one)

- (1) ☐ Currently married
 (2) ☐ Separated, divorced, or widowed
 (3) ☐ Never married

3. SEX (Check one)

- (1) ☐ Male
 (2) ☐ Female

4. EDUCATION (Check one)

- (1) ☐ Less than high school
 (2) ☐ High school graduate
 (3) ☐ Some college
 (4) ☐ College graduate (Type of degree _____)

5. SMOKE CIGARETTES?

(1) ☐ Not at all

- (2) ☐ Less than ½ pack per day
 (3) ☐ About ½ pack per day
 (4) ☐ About 1 pack per day
 (5) ☐ Over 1½ pack per day

6. DRINK COFFEE?

(1) ☐ None or rare cup

- (2) ☐ About 1-2 cups per day
 (3) ☐ 3-4 cups per day
 (4) ☐ 5 or more cups per day

7. WATCH TV?

(1) ☐ None or rarely

- (2) ☐ Less than 1 hour per day
 (3) ☐ 1-2 hours per day
 (4) ☐ 3-4 hours per day
 (5) ☐ 5+ hours per day

8. AVERAGE HOURS OF SLEEP

(1) ☐ 4-5 hours

- (2) ☐ 5-6 hours
 (3) ☐ 6-7 hours
 (4) ☐ 7-8 hours
 (5) ☐ 8 or more hours

AGE _____ 9-10

TODAY'S DATE: _____ 17-22

HEIGHT _____ feet _____ in. 11-13

Month _____ Day _____ Year _____

WEIGHT _____ pounds 14-16

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Thank you for completing the questionnaire. Your help is very much appreciated. Please check back to make sure you have not left any questions unanswered.